STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445156	A. BUILDING _____ B. WING _____	C 02/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL MANOR HEALTH CARE	902 BUCHANAN RD NEW TAZEWELL, TN 37825

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation documentation, review of facility policy, observation, and interview, the facility failed to ensure residents are free of significant medication errors for one resident (#4) of six sampled residents. The findings included: Medical record review revealed the resident (#4) was admitted to the facility on December 29, 2008, with diagnoses including Diabetes Mellitus and Hypertension. Continued review revealed the resident was readmitted to the facility on December 14, 2010, with diagnoses including Left Knee Fracture. Medical record review of a Minimum Data Set dated November 22, 2010, revealed the resident had moderate cognitive impairment, was independent with mobility, and required assistance with hygiene and dressing. Medical record review of a care plan effective through February 23, 2011, revealed, "...Provide medications...as ordered..." Medical record review of physician orders dated December 14, 2010, revealed, "Detrol...Macrodantin 100 mg (milligrams)...KCl (potassium) 20 meq (milliequivalents)...Senna...Nexium 40	F 333	**F333 D** Resident #4 was monitored closely by Licensed personnel for 24 hours with no adverse reactions. The nurse involved immediately acknowledged the error. No other residents were affected. The Nurse involved was re-educated to use the required resident identifiers while administering medications. The nurse was observed randomly during med pass over a 2 week period with compliance demonstrated during each observation. Nursing Unit managers will observe all nurses during medication administration at least annually to determine competency and compliance with use of resident identifiers while administering medication. Medication Pass observations will be discussed as a component of the facility QA program at least annually.	3-15-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janice Brungardt — TITLE: Administrator — (X6) DATE: 2/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 333	Continued From page 1 mg...Robaxin...Lidoderm patch...on AM, off PM...Lantus 10 units...qhs (at bedtime)...Lortab 7.5 mg po tid (by mouth three times daily)...Xanax 0.5 mg po tid Lantus 20 units...q am (every morning) ...Simvastin...Aricept...Isosorbide...Atenolol...(and sliding scale insulin administration)." Medical record review of a nurse's note dated December 28, 2010, at 7:35 a.m., revealed, "During medication pass this AM...received meds not ordered for (resident)...examined and alert..VS checked. Dr...was notified..." Medical record review of a nurses' notes dated December 28, 2010, revealed, "...(12:00 p.m.)...up in wheelchair...alert, oriented. able to voice needs...(1:00 p.m.)...Ate good lunch...(2:00 p.m.)...talking with family...(3:00 p.m.)...FSBS (fasting blood sugar) 339...(5:00 p.m.)...sleeping at this time wakes easily..." Medical record review of a nurse's note dated December 29, 2010, at 4:30 a.m., revealed, "...up at present, fully awake...vital signs WNL (within normal limits)..." Review of facility investigation documentation dated December 28, 2010, revealed the resident was administered the following medications in error: Vistaril 25 mg, Neurontin 300 mg, Zinc 220 mg, Xanax 1 mg, Geodon 40 mg, Depakote 250 mg, Vitamin C 500 mg, Wellbutrin SR 100 mg, Folic Acid 1 mg, MVI (multivitamin), Plavix 75 mg, Vitamin D3, Nasonex nasal spray, and Synthroid 0.025 mg. Continued review revealed, "Reason for making error nurse did not use pt (patient) identifiers when adm (administering) medications..." Review of facility policy revealed,"...To ensure that each resident is positively identified...Any	F 333		

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F 333	Continued From page 2 person administering medications...verify the resident's identify by checking...identification photo...before administering the medication..." Observation and interview with the alert, oriented resident on February 9, 2011, at 3:22 p.m., revealed the resident seated in a chair in the resident's room, dressings on the left side of the face and upper chest, and the resident stated,"...don't feel good today. Had this surgery you know (touched dressings) cancer removed...My sugar is high a lot. It's bad to drop...have to watch it..." Interview with licensed practical nurse (LPN) #2 on February 9, 2010, at 1:44 p.m., in a conference room, revealed LPN #2 failed to positively identify Resident #4 and administered another resident's medications to resident #4 on December 28, 2010. Interview with the director of nursing on February 9, 2011, at 2:02 p.m., in a conference room, revealed the acceptable standards of practice for nurses included positive identification of a patient. Continued interview confirmed the facility had failed to identify Resident #4 on December 28, 2010, resulting in a significant medication error for Resident #4. C/O: #27365	F 333		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514		

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F 514	Continued From page 3 systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete, accurate medical record for one resident (#4) of six sampled residents. The findings included: Medical record review revealed the resident (#4) was admitted to the facility on December 29, 2008, with diagnoses including Diabetes Mellitus and Hypertension. Medical record review of monthly recapitulation (summary) orders signed by a physician on December 6, 2010, revealed, "...B/S (blood sugar) 7a (a.m.)...11a...4p (p.m.)...8p...S/S insulin...Novalog 5 units ac (before meals) with each meal Lantus 20 units qd (every day) at 8 P...Lantus 20 units qam (every morning)..." Medical record review of a physician's order dated December 8, 2010, revealed, " 1. Lantus 30 units Q AM. 2. Lantus 30 units Q 8 PM (every evening)." Medical record review of a Medication Administration Record (MAR) dated December 9, 2010, revealed Novalog was initialed as	F 514	**F514 D** Resident #4 was not adversely affected by the incomplete inaccurate medical record. Medical Records clerk reviewed current medical records for completeness and accuracy. Nurses will be re-educated to the requirements of complete and accurate medical records by March 15, 2011. Medical records will be audited for complete and accurate content on a quarterly schedule as a component of the facility QA program.	3-15-2011

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F 514	Continued From page 4 administered as ordered, Lantus 20 units was initialed at 8:00 a.m. and was not initialed at 8:00 p.m. Continued review revealed Lantus 30 units was initialed at 8:00 a.m. and not initialed at 8:00 p.m. Medical record review of the MAR dated December 10, 2010, revealed Lantus 20 was not initialed at 8 a.m. or 8:00 p.m. and Lantus 30 was initialed at 8:00 a.m. Continued review revealed, "...4:00 p.m. Hosp (in hospital)...8:00 p.m. Hosp..." Medical record review revealed the resident returned to the facility on December 14, 2010. Medical record review of undated nurse's notes beginning at 11:00 a.m. through 6:00 p.m., revealed, "...11:00 AM Spoke with (responsible party) ...6 (p.m.)...no distress.." Interview with LPN #1, responsible for Medication Administration Record documentation dated December 9, 2010, on February 9, 2011, revealed she had administered Lantus 30 units at 8:00 a.m., had not administered Lantus 20 units at 8:00 a.m., and she had inadvertently documented Lantus 20 units was administered on December 9, 2010, at 8:00 a.m. Telephone interview with the director of nursing on February 11, 2011, at 10:20 a.m., revealed undated nurse's notes beginning at 11:00 a.m. through 6:00 p.m. were nurse's notes from the resident's medical record for December 28, 2010. Continued interview confirmed the resident's medical record was incomplete and inaccurate. C/O: #27365	F 514		

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